

including future medical treatment. Claimant had earlier been treated with epidural injections for a large central herniated disc identified by an MRI. Claimant was released to full duty on March 28, 1997, with a 10 percent whole person impairment which led to the settlement.

Claimant also suffered an additional onset of pain while working for St. Francis Hospital on February 28, 1998, causing him to go to the St. Francis Emergency Room with back pain and radiculopathy into his right leg. This condition improved after several days of pain medication and muscle relaxants. He testified he had no permanent problem associated with this onset of pain. Claimant then testified to the accident of March 13, 1998, as above described.

Respondent contends claimant's March 13, 1998, injury is nothing more than a temporary exacerbation of his preexisting back problems. The claimant was advised after the 1996 injury that he would have intermittent exacerbations of his back pain, which he testified have occurred. However, claimant testified that this March 13, 1998, incident is more significant in that the pain has been more severe and he is not recovering as in the past.

Respondent contends claimant was advised in 1996 of the large herniated disc, with the potential for surgery discussed in May 1997 by Dr. P. Brent Koprivica if the radiculopathy reoccurred. Subsequent to the 1996 injury, claimant was advised to avoid repetitive bending, pushing, pulling, twisting, or lifting activities by Dr. Glenn Amundson.

Claimant was examined by Dr. Edward J. Prostic, an orthopedic surgeon, at respondent's request on May 22, 1998. At that time, Dr. Prostic had the opportunity to review claimant's past history and medical records including the prior medical reports of Dr. Koprivica, Dr. Amundson, and the 1997 MRI. Dr. Prostic recognized claimant's preexisting central disc herniation at L5-S1. Dr. Prostic then opined claimant's condition had not been worsened as a result of the March 13, 1998, incident and no additional work restrictions were indicated above those previously provided by Dr. Amundson.

Claimant was referred to Dr. Sergio Delgado, an orthopedic surgeon in Topeka, Kansas, on April 3, 1998. Dr. Delgado reviewed claimant's past history but was not advised of the February 28, 1998, incident at St. Francis Hospital. He did have the opportunity to review the remainder of claimant's past medical history, including the MRI reports from 1996, and was aware of claimant's central herniation at L5-S1.

Dr. Delgado felt claimant had suffered an aggravation of his preexisting condition as a result of the March 13, 1998, incident and recommended injections and possible surgery if claimant's condition remained symptomatic.

Respondent further denies claimant suffered the incident on March 13, 1998, contending there were no witnesses to the incident. However, respondent provides no alternative explanation for the onset of pain suffered by claimant on that date.

The Appeals Board finds based upon the totality of the evidence that claimant suffered an aggravation of his preexisting condition on March 13, 1998, and is entitled to medical treatment to resolve this aggravation.

WHEREFORE, it is the finding, decision, and order of the Appeals Board that the Order of Assistant Directory Brad E. Avery dated June 1, 1998, should be, and is hereby, affirmed.

IT IS SO ORDERED.

Dated this ____ day of July 1998.

BOARD MEMBER

c: George H. Pearson, Topeka, KS
Ronald J. Laskowski, Topeka, KS
Brad E. Avery, Assistant Director
Philip S. Harness, Director